STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155787	B. WING		10/25/2012
NAME OF I	DROWNED OF CLIPPLE	TD.		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIE	A.	3851 N	RIVER RD	
INDIANA	VETERANS HOM	1E	WEST	LAFAYETTE, IN 47906	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG F0000	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCE	DATE
F0000					
	This Visit was t	for the Investigation of	F0000		
		N00118060, IN00117265,	10000		
	and IN0011741				
	and invoiring	<i>)</i> .			
	Complaint INO	0118060-Substantiated.			
	_	eficiencies related to the			
		e cited at F157, F309 and			
	F 386.	cencer at 1137, 1307 and			
	1 300.				
	Complaint INO	0117265-Unsubstantiated			
	due to lack of e				
	due to lack of e	vidence.			
	Complaint INO	0117419-Substantiated.			
	_				
		related to the allegation(s)			
	are cited.				
	Unrelated defic	iencies are cited.			
	Survey date(s):	October 22, 23, 24, & 25,			
	2012				
	Facility number	r: 001134			
	Provider numbe	er: 155787			
	AIM number: 2	200817200			
	g T				
	Survey Team:	DNI TO			
	Lora Brettnache				
	Christi Davidso	on, KN			
	Census bed type	۵۰			
	SNF/NF: 166	<b>.</b> .			
	NCC: 23				
LABORATOR	Y DIRECTOR'S OR PRO	OVIDER/SUPPLIER REPRESENTATIVE'S S	IGNATURE	TITLE	(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Facility ID:

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	of CORRECTION IDENTIFICATION NUMB.  155787	ER:	2) MULTIPLE COI BUILDING WING	00	(X3) DATE COMPI 10/25	LETED
	PROVIDER OR SUPPLIER  VETERANS HOME		3851 N I	DDRESS, CITY, STATE, ZIP CODE RIVER RD AFAYETTE, IN 47906		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENG (EACH DEFICIENCY MUST BE PRECEDED) REGULATORY OR LSC IDENTIFYING INFOR	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
	Total: 189  Census payor type: Medicare: 20 Medicaid: 126 Other: 43 Total: 189  Sample: 7 Supplemental Sample: 15  These deficiencies reflect state findicited in accordance with 410 IAC 10  Quality review completed 10/29/12 Cathy Emswiller RN	ings				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		155787	B. WING		10/25/2012	
NAME OF I	DOLUBER OR GURNIER		STREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	K	3851 N	RIVER RD		
INDIANA	VETERANS HOM	E	WEST	LAFAYETTE, IN 47906		
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
F0157 SS=D	A facility must im resident; consult physician; and if legal representat member when the resident which the potential for rintervention; a significant (i.e., a det or psychosocial streatening cond complications); a significantly (i.e., existing form of the consequences, of treatment); or discharge the resident and, if k representative or when there is a commate assign §483.15(e)(2); or under Federal or	NE/ROOM, ETC) Imediately inform the with the resident's known, notify the resident's ive or an interested family ere is an accident involving the results in injury and has requiring physician gnificant change in the al, mental, or psychosocial erioration in health, mental, status in either life itions or clinical Inneed to alter treatment Inneed to discontinue an reatment due to adverse or to commence a new form a decision to transfer or sident from the facility as				
	update the addre	record and periodically ess and phone number of pal representative or member.				
	facility failed to and/or consult w physician when	iew and record review, the inform a resident's family with the resident's a resident had a ge in blood pressure	F0157	What corrective actions will accomplished for those reside found to have been affected be the deficient practice? The Physician was notified of the change of condition of residents.	nts y	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		nnia	00	COMPL	ETED
		155787	A. BUII		<del></del> -	10/25/	2012
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R					
INIDIANA	VETERANS HOM	E			RIVER RD LAFAYETTE, IN 47906		
INDIANA	VETERANSTION	<b>_</b>		WEST	LAFATETTE, IN 47900		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG			DATE
	which had the p	otential for requiring			10/24/12. One Nurse Practition		
	physician interv	ention for 1 of 3 residents			was terminated prior to 10/24 Physician discussed with the	•	
	reviewed for ph	ysician/family notification			other Nurse Practitioner about	t the	
	(Resident #C).				documentation needed. IVH v		
					add with the credentialing page		
	Findings:				for Nurse Practioners to sign		
	i manigs.				they read the Code and will h		
	Desident //Clause				the Nurse Practitioners sign of		
		ecord was reviewed on			stating they understand prior		
		0:00 A.M. Resident #C			starting on the contract with I		
	was admitted to	the facility on 12/2/10			Physician will review charts for the Nurse Practioners on an	И	
	and had current	diagnoses which included			on-going basis.2. How will oth	ner	
	but were not lim	nited to prostate cancer			residents having the potential		
	with supra pubic	c catheter, recurrent			be affected by the same defic		
		ections, diabetes mellitus,			practice be identified and wha	nt	
	1	fibrillation, hypertension,			corrective action will be taken		
	1 -	neart failure. Resident #C			other resident's clinical record	ls	
	1				have been reviewed for		
		iented. He was being			significant changes. Proper documentation was put into		
	1	ephrologist (kidney			place, including Physician and	d	
		ding the recurrent urinary			responsible party notification.		
	tract infections.				This was done 11/2/12.3. Wh	at	
					measures will be put into place		
	Resident #C's nu	arse's notes from 7/1/2012			what systemic changes will be		
	through 9/12/20	12 were reviewed.			made to ensure that the defic		
	1	Vital Sign Flow Sheet" for			practice does not recur?The visigns flow sheet has been rev		
		012 through 9/8/2012			to indicate the nurse's signatu		
		On 9/6/2012, Resident			area. There has also been a		
					section added to the vital sign	1	
	_	sure which averaged			flow sheet for a re-take of and	l	
		2 and his oxygen			abnormal vital sign. The		
		averaged in the high 90's			Physician has given parameter		
		90% on room air. His			for each area of vital signs for		
	temperature was	s documented as 99.3. On			which he wishes to be called for above or below those	OH,	
	9/5/2012 it was	96.4. Documentation of			parameters. A new policy has	i	
	physician notific	cation was lacking in			been written for these		
		ecord. The record did not			parameters. This policy has b	een	

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	OF CORRECTION  IDENTIFICATION NUMBER:  155787	(X2) MULTIPLE CO A. BUILDING B. WING	00	(x3) DATE SURVEY COMPLETED 10/25/2012
	PROVIDER OR SUPPLIER  VETERANS HOME	3851 N	DDRESS, CITY, STATE, ZIP CODE RIVER RD AFAYETTE, IN 47906	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	DATE
	have times of when the vitals were taken or initials of who took the vitals.  During an interview on 10/24/2012 at 10:10 A.M., the DON (Director of Nursing) indicated any one who was being followed by a nephrologist (kidney specialist) had their vitals taken at a minimum of once daily. The CNAs (Certified Nursing Assistants) took the vitals and documented them on the frequency form. Nurse's were responsible to check the book daily. If the vitals were abnormal the CNAs were to immediately report the vitals to the nurse. The nurse then would assess and notify the physician if needed. Documentation should be in the nurse's notes and a notification form the facility files in a folder for the physician's to look at when they were at the facility. The DON was asked to provide documentation the physician and or family was notified of the abnormal vitals on 9/6/2012.  During an interview on 9/24/2012 at 12:20 P.M., the DON indicated she could not find documentation of the physician or family being notified of the abnormal vitals. She indicated she spoke with the nurse who cared for Resident #C on 9/6/2012 and she could not recall being aware of the abnormal vitals. The DON indicated because there were no initials		in-serviced to all nursing staff the medical group. The will be done by 11/14/12.4. How will to corrective action be monitored ensure the deficient practice wont recur? The nurse unit managers and supervisors will audit all vital sign flow sheets daily x 30 days, weekly x one month, monthly x 3 months, the quarterly there after to manage any discrepancies in the policy. This will start on 11/1/12. This be reported to QA monthly for months and then quarterly thereafter.	he to vill en e e v.

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	OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	00	(X3) DATE SURVEY  COMPLETED
I I I I I I I I I I I I I I I I I I I	155787	A. BUILDING		10/25/2012
	.55.5.	B. WING	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIER		RIVER RD	
INDIANA	VETERANS HOME		_AFAYETTE, IN 47906	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG	on the vitals form she could not find out	TAG	BLI ICILICE I	DATE
	who documented the vitals. The DON			
	indicated two Nurse Practitioners (NP)			
	were here on 9/6/2012. NP #1 addressed			
	Resident #C's indigestion and gave orders			
	for an antacid. The DON called NP #1			
	and she indicated NP #1 told her she did			
	not recall being told about any abnormal			
	labs. NP #1 did not write a progress note			
	for this visit. The DON called NP #2. NP			
	#2 indicated to the DON she did not			
	remember being told about the abnormal			
	vitals. NP #2 indicated to the DON she			
	only recalled consulting with Resident #C			
	regarding his DNR (do not resuscitate)			
	status. She did not write a progress note			
	for this visit.			
	A current facility policy titled "Physician			
	contact" provided by the DON on			
	10/22/2012 indicated, "STAT			
	PHYSICIAN CONTACTThe			
	following symptoms/signs and examples			
	of situations that require immediate			
	notification are not to be all-inclusive. If			
	unsure about the situation, notify the			
	physician/NP Change in vital signs			
	outside ordered parameters or general			
	guidelines: Blood pressure greater than			
	200 systolic or less than 90 diastolic"			
	This Federal tag relates to Complaint			
	IN00118060.			
	L			I

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155787	(X2) MULTIPLE CO  A. BUILDING B. WING	00		TE SURVEY MPLETED 25/2012
	PROVIDER OR SUPPLIE		3851 N	ADDRESS, CITY, STATE, ZI RIVER RD LAFAYETTE, IN 4790		
(X4) ID PREFIX TAG	(EACH DEFICIE REGULATORY O	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	CORRECTION IN SHOULD BE HE APPROPRIATE ()	(X5) COMPLETION DATE
	3.1-5(a)					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155787		LDING	00	(X3) DATE : COMPL 10/25/	ETED
	PROVIDER OR SUPPLIER			3851 N	ADDRESS, CITY, STATE, ZIP CODE RIVER RD LAFAYETTE, IN 47906		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
F0309 SS=D	must provide the services to attain practicable physic psychosocial well the comprehensive care.  Based on interviet facility failed to resident with an for 1 of 3 resider (Resident #C).  Findings:  Resident #C's real 10/23/2012 at 10 was admitted to and had current of but were not limprostate cancer we catheter, recurred diabetes mellitus fibrillation, historeflux, hypertens lower extremity congestive heart edema. Resident oriented. He was nephrologist regardents.	BEING st receive and the facility necessary care and or maintain the highest	F03	09	1. What corrective action will accomplished for those reside to have been found to have be affected by the deficient pract Physician was notified of abnormal blood pressure and change in other vital signs on 10/24/12.2. How will others having the potential to be affe by the deficient practice be identified and what corrective action will be taken? All vital si flow sheets were reviewed for abnormal vital signs. The Physician set new parameters all vital signs and any abnorm were reported to the Physician Nurse Practitioner and family. This was done by 11/2/12.3. What systemic changes will be made to assure the deficient practice does not occur again New parameters were set for vital signs by the Physician. Baseline vital signs were determined for all current residents and will be determined for all new residents after one month. Policy changes were made regarding follow up assessment of residents being sent to the hospital for conditions.	ents een ice?  cted  ggns afor eal n / e ? all	11/24/2012

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	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER:  155787	(X2) MULTIPLE CON	NSTRUCTION  00	(X3) DATE SURVEY COMPLETED 10/25/2012
	PROVIDER OR SUPPLIER A VETERANS HOME	3851 N F	DDRESS, CITY, STATE, ZIP CODE RIVER RD AFAYETTE, IN 47906	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	DATE
	Resident #C's nurse's notes from 7/1/2012 through 9/12/2012 were reviewed. Resident #C's "Vital Sign Flow Sheet" for the dates 8/20/2012 through 9/8/2012 were reviewed. On 9/6/2012, Resident #C's blood pressure which averaged 100/60 was 62/42 and his oxygen saturation which averaged in the high 90's on room air was 90% on room air. His temperature was documented as 99.3. Documentation of an assessment was lacking in Resident #C's record. The record did not have times of when the vitals were taken or initials of who took the vitals.  During an interview on 10/24/2012 at 10:10 A.M., the DON (Director of Nursing) indicated any resident who was being followed by the nephrologist (kidney specialist) had their vitals taken at a minimum of daily. The CNAs (Certified Nursing Assistants) took the vitals and documented them on the frequency form but it was the nurses responsibility to check if they were done and what they were. If the vitals were abnormal the CNAs were to immediately report the vitals to the nurse. The nurse then would assess and notify the physician if needed. If something was abnormal for a resident, documentation should be in the nurse's notes and on a notification form the facility filed in a		changes. All parameter change determination of baseline vital signs, and policy changes will in-serviced to all nurses, QMA CNAs, and the medical group 11/14/12.4. How will the change be monitored for effectiveness All vital sign flow sheets will be monitored by the nurse unit manager daily x 4 weeks starti 11/1/12, then monthly x 3 monthen quarterly thereafter and results reported to QA. Any patient sent out to the hospital a change in condition will resu an audit of the assessment an follow up assessment on vital signs and condition for each so ou for 30 days by the nurse un manager, beginning 11/5/12. After the first 30 days, 50% of send outs on each unit will be randomly audited by the nurse unit manager for 3 months, the 50% of each unit randomly audited by the reported to QA.	be s, by ges ? e mg ths, for lt in d end it

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155787		LDING	NSTRUCTION  00	(X3) DATE COMPI 10/25	ETED
	PROVIDER OR SUPPLIER		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE RIVER RD AFAYETTE, IN 47906	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
	they were at the asked to provide #C was assessed abnormal vitals of During an interving 12:20 P.M., the land find docume being assessed dispressure. She in the nurse who can 9/6/2012 and she aware of the abnormal vitals form who documented indicated becaus on the vitals form who documented indicated two Nurver here on 9/6 Resident #C's interventional for an antacid. The analysis of the provided for this visit. The #2 indicated to the remember being vitals. NP #1 did for this visit. The #2 indicated to the remember being vitals. NP #2 indicated to the regarding his DN status. She did to this visit.	ysician's to look at when facility. The DON was documentation Resident at the time of the on 9/6/2012.  iew on 9/24/2012 at DON indicated she could ntation of Resident #C ue to the low blood dicated she spoke with ared for Resident #C on e could not recall being formal vitals. The DON to the there were no initials in she could not find out the vitals. The DON for the Practitioners (NP) /2012. NP #1 addressed digestion and gave orders the DON called NP #1 told her she did told about any abnormal not write a progress note of DON she did not told about the abnormal dicated to the DON she issulting with Resident #C JR (do not resuscitate) not write a progress note ented blood pressure was					

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	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155787	LDING	NSTRUCTION 00	(X3) DATE COMPI 10/25	
	PROVIDER OR SUPPLIER		STREET A	.DDRESS, CITY, STATE, ZIP COD RIVER RD .AFAYETTE, IN 47906	E	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPF DEFICIENCY)	.D BE	(X5) COMPLETION DATE
	The record lacke Resident #C bein time. The only n	time) and was 95/46. d documentation of ng assessment at this urse's note dated for ented dressing changes to ounds.				
	Contact" provide 10/22/2012 indic greater than 200 less than 90 dias	y policy titled "Physician ed by the DON on eated a blood pressure systolic (top number) and tolic (bottom number) general guidelines for a				
	1:55 P.M., LPN should report to	iew on 10/24/2012 at #4 indicated CNAs a nurse immediately if a pressure was 62/42.				
	1:58 P.M., CNA immediately tell blood pressure w	iew on 10/24/2012 at #9 indicated she would a nurse if a resident's vas below 90/70. She ediately told a nurse if it				
	2:05 P.M., LPN #10, all indicated resident's blood they would reche themselves and a	iew on 10/24/2012 at #5, LPN #6, and LPN difference told a pressure was abnormal each the blood pressure assess the resident. When wrote the vitals in the				

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	OF CORRECTION  IDENTIFICATION NUMBER:  155787	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	(X3) DATE SURVEY COMPLETED 10/25/2012
	PROVIDER OR SUPPLIER  VETERANS HOME	3851 N	ADDRESS, CITY, STATE, ZIP CODI RIVER RD LAFAYETTE, IN 47906	Е
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE COMPLETION
	frequency book without telling a nurse what would they do. They all indicated they were to check the frequency book during their shift to make sure the vitals were completed.			
	During an interview on 10/24/2012 at 2:12 P.M., CNA #10 indicated if the blood pressure was abnormal she would take it again and then tell the nurse. She indicated anything below 112/48 or 98/50 was abnormal and would be verbally told to a nurse.			
	A nurse's note dated 9/8/2012 at 8:20 A.M., indicated, "complaining of chest pain-vitals 98.6 86-18-103/61-94% on room airgiven dose of ES Maalox and told if it didn't help let staff know.			
	A nurse's note dated 9/8/2012 8:50 A.M., indicated, "States chest still hurts-call placed to supervisor, then MD." A nurse's note dated 9/8/2012 at 9:20 A.M. indicated, "NP returned call-new RXs (orders) received."			
	A nurse's note dated 9/8/12 at 9:25 A.M. indicated, "Resident stated chest pain was letting up-wanted Nitro SL (sublingual) anyway, which was given." The record lacked documentation of a thorough assessment of Resident #C's condition including vitals with his continued			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155787	B. WIN	G		10/25/	2012
NAME OF B	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUFFLIER			3851 N	RIVER RD		
INDIANA	VETERANS HOME			WESTL	_AFAYETTE, IN 47906		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	complaints of chest pain						
	A nurse's note da	ated 9/8/2012 at 12:10					
	P.M. indicated, "	Put in w/c (wheel chair)					
	for lunch-compla	ained of chest pain-P 91,					
	R 20, B/P 67/45,	O2 Sat 98%-sleeping in					
	w/c-unable to give	ve nitro due to decreased					
		d) notified and RX					
	`	to send to ER for					
	` ′	ng supervisor was					
	notified prior to						
	notified prior to						
	A nursals nota de	nted 9/8/2012 at 12:40					
		s after the order was					
	`						
		Resident #C to ER)					
	indicated, "call p	laced to ambulance."					
	The record lacke	ed documentation of an					
	assessment or a s	second blood pressure					
		.M. blood pressure of					
	67/45 was docum	•					
	A nurse's note da	ated 9/8/2012 at 1:00					
		'Ambulance here for					
	pick-up."	Authoritance here for					
	pick-up.						
	A nurse's note de	ated 9/8/2012 at 5:45					
		Resident #C's wife called					
	_	nformed them Resident					
	1	mitted to the hospital					
	with complete re	nal failure.					
		10/45/0040					
		ated 9/15/2012 titled					
	Discharge summ	ary indicated Resident					

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	OF CORRECTION IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED				
	155787	B. WING		10/25/2012				
INDIANA	PROVIDER OR SUPPLIER  VETERANS HOME	STREET ADDRESS, CITY, STATE, ZIP CODE  3851 N RIVER RD  WEST LAFAYETTE, IN 47906						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE				
	#C was sent to the emergency room on 9/8/2012. Labs were drawn and he was found to be in renal failure. The patient was admitted, had multi-organ failure, which led to the election of hospice care. The patient expired on 9/12/2012.  A facility policy titled "Vital Signs" provided by the Superintendent on 10/23/12 indicated: "It is the intent of the Indiana's Veterans' Home (IVH) that all Nursing Home Care residents shall have their vital signs and weight taken and recorded at least monthly and as needed. although nurses aides and Qualified Medical Assistants may take resident vital signs, any abnormal vital signs are to be immediately reported to the nurse."  This Federal tag relates to Complaint IN00118060.  3.1-37(a)							

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155787			(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 10/25/2012
NAME OF F	ROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE RIVER RD	
INDIANA	VETERANS HOM	E		LAFAYETTE, IN 47906	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPL	ETED
		155787	B. WIN		<del></del>	10/25/	2012
			D. WIIV	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				RIVER RD		
INIDIANA	VETERANS HOME	=			LAFAYETTE, IN 47906		
				WEST	LAI ATETTE, IN 47 900		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0323	483.25(h)						
SS=E	FREE OF ACCID						
		RVISION/DEVICES					
	_	ensure that the resident					
		ains as free of accident					
	•	sible; and each resident e supervision and					
		es to prevent accidents.					
		ation, interview and	F03	23	1. What action was taken to		11/24/2012
		-	1.03	43	correct the deficient practice?	The	11/24/2012
		he facility failed to ensure			bed was removed from the roo		
		reen the bed rails and			immediately and replaced with		
	mattress or spaci	ng between the bars of			the proper bed with the		
	the bed rails met	safety requirements for			acceptable railing.2. How are		
	15 of 189 beds u	sed in the facility. (#I,			other identified and what		
		#N, #O, #P, #Q, #R, #S,			corrective action will be taken	to	
					prevent it from occurring again		
	#T, #U, #V, #W)	)			to others?All residents' beds o	n	
					campus were inspected for		
	Findings include	:			unacceptable measurements		
					regarding the rail safety and all beds that did not meet	I	
	Facility wide rou	inds in the presence of			specifications were removed. I	\/LI	
	the DoN, RN #2	•			implemented a "Bed Rail Zone		
	·	/24/12 at 2:30 p.m. until			Appropriate Dimensions and	.5,	
		*			Appropriate Usage" policy and		
	*	ew the safety of all			trained all employees on the 7		
		d to identify resident beds			zones of entrapment.3. What		
	with unsafe bed	rail zones or unsafe			measures or systemic changes		
	mattress zones w	ith the potential for			were put into place to be sure	this	
	entrapment.				does not reoccur?The policy		
					states that all beds will be aud	ited	
	1 The record fo	r Resident #I was			every quarter by the Safety		
					Officer. All 7 zones will be checked and documented and		
	1eviewed on 10/2	25/12 at 10:59 a.m.			turned into the Physical Plant		
					Director for auditing purposes.	4.	
	Diagnoses include	ded but were not limited			How will corrective actions be		
	to diabetes and h	yperlipidemia.			monitored?Quarterly PMs will	be	
					sent to the Safety Officer to ch		
	A nurses note da	ted 10/21/12 at 0300			all beds per policy and docume		
	11 marses more da	10/21/12 at 0500			on a log. The measurement log	g	
			1		Ī		i

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155787		A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPL 10/25/	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  3851 N RIVER RD  WEST LAFAYETTE, IN 47906					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
	able to make need gait steady. ADD living] per self [strong supervision."  During an observed 2:21 p.m., Resided with bilatera Bilateral lowers the bed but not in One of the upper three large open inches within the lower rails each areas greater that rails.  During an observed 2:26 p.m., the Dot three large open on the upper side lower side rails.  Resident #I's beet those openings winches each.  2. The record for reviewed on 10/2 Diagnoses included.	ated, "Speech clear, ds knownAmbulating, L's [activities of daily sign for with]  vation on 10/24/12 at ent #I was sitting on his I upper side rails raised. ide rails were attached to a the raised position. Traised side rails had areas greater than 4 3/4 erail, and both of the had three large open in 4 3/4 inches within the areas with a tape measure erail and both of the Within the side rails on I the measurements of were 7.75 inches by 8.0  The Resident #J was 25/12 at 11:02 a.m.  Ided but were not limited inchitis and difficulty			will then be sent to the Physic Plant Director to sign-off on. any bed fails the checks, the Safety Officer will make out a safety work order and it will be turned over to maintenance to repair immediately.5. Change completed by:Beds were removed immediatelyPolicy who be approved by QA at the November meeting	f e o es		

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155787		(X2) MULT A. BUILDI B. WING		NSTRUCTION  00	(X3) DATE : COMPL 10/25/	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  3851 N RIVER RD  WEST LAFAYETTE, IN 47906					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID EFIX FAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	indicated Reside score of 15 out of cognition on the Mental Status (B) with bed mobility. During the facility for bed rail safety p.m. until 4:00 p was observed with areas within 7.5 inches by 9 is lower rails were position.  3. The record for reviewed on 10/2 Diagnoses included to diabetes, hypedementia/Alzheithem The most recent (MDS) Assessman Resident #K was 4 out of a possib BIMS. Resident correct year and 3 words given for was assessed for the most recent was assessed for the most recent correct year and 3 words given for was assessed for the most recent was assessed for the most recent year and 3 words given for was assessed for the most recent year and 3 words given for was assessed for the most recent year and 3 words given for was assessed for the most recent year and 3 words given for was assessed for the most recent year.	ty wide rounds to review y on 10/24/12 at 2:30 c.m., Resident #J's bed th bilateral lower rails in the rail that measured inches. The bilateral not observed in the raised or Resident #K was 25/12 at 11:05 a.m.						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				00	(X3) DATE COMPL		
		155787	A. BUII B. WIN	LDING		10/25/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUPPLIER				RIVER RD		
INDIANA	VETERANS HOME	<u> </u>		WEST L	AFAYETTE, IN 47906		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	During the facili	ty wide rounds to review					
	_	y on 10/24/12 at 2:30					
		.m., Resident #K's bed					
	-	th bilateral lower rails					
		the rail that measured					
		.5 inches, 7.5 inches by					
		2.25 inches by 7.5 inches.					
	-	ver rails were not					
	observed in the r	raised position.					
		•					
	4. The record fo	r Resident #L was					
	reviewed on 10/2	25/12 at 11:10 a.m.					
	_	ded but were not limited					
	to depression and	d dementia.					
	The most recent	Minimum Data Set					
		ent dated 9/16/12					
	` ′	nt #L was assessed with a					
		of a possible 15 for					
		BIMS. Resident #L					
	•	ect year and recalled 2 of					
	-	n for recall. Resident #L					
	_	extensive assistance with					
	one person physi	ical assistance for bed					
	mobility and tran						
	During the facili	ty wide rounds to review					
	· ·	y on 10/24/12 at 2:30					
	p.m. until 4:00 p	.m., Resident #L's bed					
		th a gap between the					
		ne mattress that measured					
	7.5 inches with t	he head of the bed down.					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION 00	(X3) DATE COMPL		
		155787	1	LDING		10/25/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER				RIVER RD		
INDIANA	VETERANS HOME	<u> </u>		WESTL	AFAYETTE, IN 47906		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	5 The record fo	or Resident #M was					
		25/12 at 11:14 a.m.					
	Diagnoses include	ded but were not limited					
	to hypertension,	obesity and congestive					
	heart failure.						
		Minimum Data Set					
	· ·	ent dated 10/3/12					
		nt #M was assessed with					
		of a possible 15 for					
	_	BIMS. Resident #M rect day of the week and					
	•	eing 2 of the 3 words					
		Resident #M was					
	_	ervision and set up					
	assistance for be	_					
		one person physical					
	assistance for tra	insfers.					
	_	ty wide rounds to review					
		y on 10/24/12 at 2:30					
	-	.m., Resident #M's bed					
		th bilateral lower rails					
		in each rail that measured					
	_	nches. The bilateral					
		not observed in the raised					
	position.						
	6. The record fo	r Resident #N was					
	reviewed on 10/2	25/12 at 11:19 a.m.					
	Diagnoses include	ded but were not limited					
							l

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155787		(X2) MU A. BUIL		NSTRUCTION 00	(X3) DATE COMPL 10/25/	ETED	
		155787	B. WING			10/25/	2012
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
INIDIANIA	VETERANGLIONE	_			RIVER RD		
INDIANA	VETERANS HOME	<u>-</u>		WESIL	_AFAYETTE, IN 47906		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	to history of falls	s and diabetes.					
	(MDS) Assessment Resident #N was 13 out of a possifith BIMS. Resident Holder Holder Resident Holder	Minimum Data Set ent dated 9/5/12 indicated assessed with a score of ble 15 for cognition on dent #N reported the correct month within 5 rect day of the week. assessed for supervision d mobility and set up for transfers.  ty wide rounds to review y on 10/24/12 at 2:30 .m., Resident #N's bed th bilateral lower rails within each rail that these by 9 inches. The fails were not observed in on.  r Resident #O was 25/12 at 11:23 a.m.  ded but were not limited copathy, depression and					
		of a possible 15 for BIMS. Resident #O was					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION 00	(X3) DATE S COMPL		
THIE TEAT	or condition	155787		LDING		10/25/	
			B. WIN		DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUPPLIER				RIVER RD		
INDIANA	VETERANS HOME	≣			AFAYETTE, IN 47906		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
IAG		ted assistance with one		TAG	DEFICIENCT)		DATE
		assistance for bed					
	mobility and trai	isieis.					
	During the facili	ty wide rounds to review					
	for bed rail safet	y on 10/24/12 at 2:30					
		.m., Resident #O's bed					
	-	th a gap between the					
	head board and t						
	measured 6.5 inc	ches with the head of the					
	bed down.						
		D 11					
		r Resident #P was					
	reviewed on 10/2	25/12 at 11:26 a.m.					
	Diagnoses includ	ded but were not limited					
		ertension and major					
	depression.	arvangion with major					
	p						
	The most recent	Minimum Data Set					
	(MDS) Assessm	ent dated 7/29/12					
	indicated Reside	nt #P was assessed with a					
	score of 7 out of	a possible 15 for					
	cognition on the	BIMS. Resident #P did					
	not report the co	rrect time and recalled 2					
	_	iven for recall. Resident					
	#P was assessed	for limited assistance					
	•	physical assistance for					
	bed mobility and	l transfers.					
	D	٠					
	_	ty wide rounds to review					
		y on 10/24/12 at 2:30					
	•	.m., Resident #P's bed					
	was observed wi	th bilateral lower rails					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	00	(X3) DATE ( COMPL		
ANDILAN	or correction	155787		LDING		10/25/	
		100707	B. WIN		DDDDGG CITY CTATE TIP CODE	10/20/	2012
NAME OF F	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE RIVER RD		
INDIANA	VETERANS HOME	<u> </u>			_AFAYETTE, IN 47906		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	with 3 areas with						
		ches by 9 inches. The					
		nils were not observed in					
	the raised position	on.					
	9 The record fo	r Resident #Q was					
		25/12 at 11:29 a.m.					
	13,10,134 011 10/2	-0, 1- w 11.27 will.					
	Diagnoses includ	ded but were not limited					
		isease and neuropathic					
	pain.						
	•						
	The most recent	Minimum Data Set					
	(MDS) Assessm	ent dated 9/2/12 indicated					
	Resident #Q was	s assessed with a score of					
	13 out of a possi	ble 15 for cognition on					
	the BIMS. Resid	dent #Q reported the					
	correct year and	the correct month within					
	5 days and recall	led 2 of the 3 words given					
	for recall. Resid	ent #Q was assessed a					
		e with one person					
	physical assistan	ce for bed mobility and					
	transfers.						
	During the facili	ty wide rounds to review					
	for bed rail safet	y on 10/24/12 at 2:30					
	p.m. until 4:00 p	.m., Resident #Q's bed					
	was observed wi	th bilateral lower rails					
	with 3 areas with	nin each rail that					
	measured 7.5 inc	ches by 9 inches. The					
	bilateral lower ra	nils were not observed in					
	the raised position	on.					
	10. The record f	For Resident #R was					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE ( COMPL		
ANDILAN	OF CORRECTION	155787	A. BUI	LDING	00	10/25/	
		133767	B. WIN			10/23/	2012
NAME OF F	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
INDIANA	VETERANS HOME	<u> </u>			RIVER RD _AFAYETTE, IN 47906		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	1	ID			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IIE.	DATE
	reviewed on 10/2	25/12 at 11:33 a.m.					
	Diagnoses included to peripheral neuron	ded but were not limited propathy.					
	The most recent	Minimum Data Set					
		ent dated 10/9/12					
	` ′	nt #R was assessed with					
		of a possible 15 for					
		BIMS. Resident #R did					
	•	rrect year or month and					
	-	3 words given for recall.					
		assessed as supervision					
		physical assistance for bed					
	mobility and tran	-					
	incernity with true						
	During the facili	ty wide rounds to review					
	_	y on 10/24/12 at 2:30					
		.m., Resident #R's bed					
	-	th bilateral lower rails					
	with 3 areas with	nin each rail that					
	measured 7.5 inc	ches by 9 inches. The					
		nils were not observed in					
	the raised position						
	11 The 1 (	San Dani dant #C					
		For Resident #S was					
	reviewed on 10/2	25/12 at 11:41 a.m.					
	Diagnoses includ	ded but were not limited					
	to hemiplegia an						
	to nonnpiogia an	a joint pain.					
	The most recent	Minimum Data Set					
	(MDS) Assessm	ent dated 9/18/12					
	` ′	nt #S was assessed with a					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION 00	(X3) DATE : COMPL		
THIE TEAT	or condition	155787		LDING		10/25/	
			B. WIN		DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				RIVER RD		
INDIANA	VETERANS HOME	<u> </u>			AFAYETTE, IN 47906		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		of a possible 15 for		TAG	DEFICIENCE I		DATE
		BIMS Resident #S was					
	_	tensive assistance with a					
		ical assistance for bed					
		ensive assistance with					
	1	ical assistance for					
	transfers.						
	During the facili	ty wide rounds to review					
	for bed rail safet	y on 10/24/12 at 2:30					
	p.m. until 4:00 p	.m., Resident #S's bed					
	was observed wi	th bilateral lower rails					
	with 3 areas with	nin each rail that					
		ches by 9 inches. The					
		ails were not observed in					
	the raised position	on.					
	12. The record f	For Resident #T was					
	reviewed on 10/2	25/12 at 11:44 a.m.					
	Diagnoses include	led but were not limited					
	to depression, ce	rebral vascular accident					
	with hemiparesis	s and dysphagia.					
	The most recent	Minimum Data Set					
		ent dated 8/17/12					
	` ′	nt #T was assessed with a					
		a possible 15 for					
		BIMS. Resident #T did					
	_	rrect year, month or day					
	of the week and	recalled 0 of the 3 words					
	given for recall.						
	During the facili	ty wide rounds to review					
	<i>G</i> :						

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	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155787	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 10/25/2012			
	PROVIDER OR SUPPLIER  VETERANS HOME	STREET ADDRESS, CITY, STATE, ZIP CODE  3851 N RIVER RD  WEST LAFAYETTE, IN 47906					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	for bed rail safety on 10/24/12 at 2:30 p.m. until 4:00 p.m., Resident #T's bed was observed with bilateral lower rails with 3 areas within each rail that measured 7.5 inches by 9 inches. The bilateral lower rails were not observed in the raised position.  13. The record for Resident #U was reviewed on 10/25/12 at 11:47 a.m.  Diagnoses included but were not limited to anemia and mild chronic obstructive pulmonary disease.  The most recent Minimum Data Set (MDS) Assessment dated indicated Resident #U was assessed with a score of 2 out of a possible 15 for cognition on the BIMS. Resident #U did not report the correct year, month or day of the week and recalled 1 word with cueing of the 3 words given for recall.  During the facility wide rounds to review for bed rail safety on 10/24/12 at 2:30 p.m. until 4:00 p.m., Resident #U's bed was observed with bilateral lower rails with 3 areas within each rail that measured 7.5 inches by 9 inches. The bilateral lower rails were not observed in the raised position.						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155787		A. BUIL	DING	NSTRUCTION  00	(X3) DATE S COMPL 10/25/	ETED	
NAME OF PROVIDER OR SUPPLIER INDIANA VETERANS HOME			B. WINC	STREET A	DDRESS, CITY, STATE, ZIP CODE RIVER RD AFAYETTE, IN 47906	1 .0.20	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
		for Resident #V was 25/12 at 11:51 a.m.					
	Diagnoses included to cerebral aneur hemiparesis and						
	(MDS) Assessment indicated Reside a score of 8 out of cognition on the reported the correlates and the incompared the incompared the correlates and the correlates and the incompared the correlates and the corre	Minimum Data Set ent dated 8/16/12 nt #V was assessed with of a possible 15 for BIMS. Resident #V ect year, month within 5 orrect day of the week the 3 words given for					
	for bed rail safety p.m. until 4:00 p was observed wi and bilateral low within each rail t by 9 inches. The were observed in bilateral lower ra the raised position	ty wide rounds to review y on 10/24/12 at 2:30 c.m., Resident #V's bed th bilateral upper rails er rails with 3 areas that measured 7.5 inches to bilateral upper rails at the up position. The tails were not observed in the upper rails on the upper rails at the upper rails at the upper rails of the upper rails at the upper rails of the upper rails at the upper rails at the upper rails of the upper rails at the upper rails of the					
	_	led but were not limited umatic brain injury.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155787		(X2) MUI A. BUILI B. WING	DING	NSTRUCTION  00	(X3) DATE COMPL 10/25/	ETED		
NAME OF PROVIDER OR SUPPLIER INDIANA VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE  3851 N RIVER RD  WEST LAFAYETTE, IN 47906					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	Ε	(X5) COMPLETION DATE	
	indicated Reside a score of 12 out cognition on the reported the correct mont words given for  During the facili for bed rail safet p.m. until 4:00 p was observed wi with 3 areas with measured 7.5 inc bilateral lower rathe raised position. LPN #1, the aware of the spemeasurements return the resident's zones.  During an intervent p.m., LPN #1, the aware of the spemeasurements return the unit manage to the resident's zones.  During an intervent p.m., the DoN we specific acceptable regarding bed ratindicated mainter facility wide chemical score indicated mainter facility wide chemical score in the score indicated mainter facility wide chemical score in the score indicated mainter facility wide chemical score in the sc	ty wide rounds to review y on 10/24/12 at 2:30 c.m., Resident #W's bed th bilateral lower rails min each rail that ches by 9 inches. The mils were not observed in on.  iew on 10/24/12 at 2:22 e unit manager, was not cific acceptable garding bed rail safety. For called the DoN to come bed to evaluate for unsafe on the one measurements il safety. The DoN nance personnel did a ck for bed rail safety last was not aware there were						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155787		JMBER:	. BUILDING . WING	COMPLETED 10/25/2012				
NAME OF PROVIDER OR SUPPLIER INDIANA VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE  3851 N RIVER RD  WEST LAFAYETTE, IN 47906					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (EACH DEFICIENCY MUST BE PRECEE REGULATORY OR LSC IDENTIFYING IN	DED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE			
	During an interview on 10/24/12 p.m., the Executive Director [ED aware of the specific acceptable measurements regarding bed rail but the ED recognized 7.5 inches inches was too large.  A facility policy dated 10/23/12 indicat "POLICY AND PROCEDURE: Bed Zones, Appropriate Dimensions and Al UsageIt is the intent of the Indiana V. Home that all beds have bed rails with dimensions per FDA guidelines, so as the entrapment issues with residentsPer the FDA guidelines, mattresses may not be than 4 3/4 inches from the head or foot the bedPer the current FDA guideline rail zone can be no greater that 4 3/4 in wide"  3.1-45(a)(2)	safety, s by 9  ted, I Rail ppropriate eteran's appropriate to avoid any he current further board of es, the bed						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X			(X3) DATE S	(3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00 COMPLET			ETED		
		155787		B. WING		10/25/2012	
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				RIVER RD		
INDIANA	VETERANS HOME	<u> </u>			LAFAYETTE, IN 47906		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0386 SS=D	total program of cand treatments, a paragraph (c) of total progress not and date all order influenza and provaccines, which rephysician-approvassessment for considering the progress note for residents reviews #C).  Findings:  Resident #C's real 10/23/2012 at 10 was admitted to and had current of but were not limprostate cancer we catheter, recurred diabetes mellitus fibrillation, historeflux, hypertens lower extremity congestive heart edema. Resident oriented. He was	RDERS ust review the resident's care, including medications at each visit required by this section; write, sign, and tes at each visit; and sign res with the exception of eumococcal polysaccharide may be administered per ed facility policy after an	F03	86	1. What corrective action will be accomplished for those reside who have been found to be deficient by the practice? Physician and Nurse Practition were notified of the deficient practice on 10/30/12.2. How wo others having the potential to be affected by the deficient practice be corrected? All charts were reviewed for the mandated 30 60, 90 day visits and the annuvisits to assure the progress notes were there and up to da Results were reported to QA. was done by 11/5/12. All patie charts were reviewed for order progress notes, signatures, da and times by Physician and Nurse Practitioner. Results reported QA by Physician and Nurse Practitioner. This will be done 11/12/12.3. What systemic changes will take place to assist the deficient practice does not occur again? Charts will be pull on scheduled visit days to separate chart rack for Physician d Nurse Practitioner review.	nts ner rill pe ce , al te. This nt rs, tes urse to by ure led an	11/24/2012

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY  COMPLETED		
AND PLAN	OF CORRECTION	155787	A. BUI	LDING	00		
155767		B. WIN			10/25/	2012	
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
INDIANA	VETERANS HOME	<u> </u>			RIVER RD _AFAYETTE, IN 47906		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG			DATE
	urinary tract infe	ections and kidney			items needing signed, dated o	r	
	disease.				timed will be flagged for the Physician / Nurse Practitioner.		
					Progress notes will be flagged		
	Resident #C's nu	rse's notes from 7/1/2012			serve as a reminder to docume		
	through 9/12/201	12 were reviewed.			at each acute visit or regulator		
	Resident #C's "V	ital Sign Flow Sheet" for			visit. In-servicing will be done vight in Physician / Nurse Practitioner,		
	the dates 8/20/20	012 through 9/8/2012			and all nurses on new process		
	were reviewed.				with charts as well as regulation	ns	
	On 9/6/2012, Re	esident #C's blood			for documentation by 11/14/12		
	pressure which a	veraged 100/60 was			How will changes be monitore for effectiveness?Nursing will	d	
	62/42 and his ox	ygen saturation which			monitor the compliance with the	ie	
	averaged in the l	nigh 90's on room air was			30, 60, 90 day and annual visi		
	90% on room air	. His temperature was			on a monthly basis and report		
	documented as 9	9.3. Documentation of			compliance to QA, Physician a		
	an assessment w	as lacking in Resident			Nurse Practitioner. All acute vi will be tracked by nursing for t		
	#C's record. The	e record did not have			first 30 days for complete orde		
	times of when th	e vitals were taken or			with date, signature, time, and		
	initials of who to	ook the vitals.			notes. After 30 days, acute vis will be randomly audited at the	;	
	During an interv	iew on 10/24/2012 at			sample size of 60% by nursing 30 days; then 30% for 30d; the		
	_	DON (Director of			10% of acute visits thereafter.		
	, , , , , , , , , , , , , , , , , , ,	ed any resident who was			This is to begin for acute visits	on	
	•	by the nephrologist			11/5/12.		
	_	t) had their vitals taken					
		daily. The CNAs					
		ng Assistants) took the					
	*	nented them on the					
	frequency form	but it was the nurses					
		check if they were done					
		ere. If the vitals were					
		IAs were to immediately					
		to the nurse. The nurse					
	then would asses						
		led. If something was					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155787			LDING	NSTRUCTION  00	(X3) DATE COMPI <b>10/25</b>			
NAME OF PROVIDER OR SUPPLIER INDIANA VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE  3851 N RIVER RD  WEST LAFAYETTE, IN 47906					
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE	
	should be in the notification form folder for the phy they were at the asked to provide #C was assessed abnormal vitals of During an interv 12:20 P.M., the land find docume being assessed dipressure. She in the nurse who ca 9/6/2012 and she aware of the abnindicated becaus on the vitals form who documented indicated two Nuwere here on 9/6 Resident #C's indicated two Nuwere here on 9/6 Resident #C's indicated to the trecall being the labs. NP #1 did for this visit. The #2 indicated to the remember being vitals. NP #2 indicated corregarding his DN movements.	esident, documentation nurse's notes and on a the facility filed in a spician's to look at when facility. The DON was documentation Resident at the time of the on 9/6/2012.  The property of the on 9/6/2012 at DON indicated she could need to the low blood dicated she spoke with red for Resident #C on a could not recall being formal vitals. The DON the there were no initials in she could not find out the vitals. The DON for the reaction of the property of the						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155787		A. BUILDING  B. WING	COMPLETED 10/25/2012					
NAME OF PROVIDER OR SUPPLIER INDIANA VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE  3851 N RIVER RD  WEST LAFAYETTE, IN 47906					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
IAU	for this visit.  This Federal tag relation in the second of the second o							

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